B A N N E R P A G E

B R 2 0 0 5 1 3 M A R C H 2 9 , 2 0 0 5

To All Providers:

- The Indiana Health Coverage Programs (IHCP) will allow Current Procedural Terminology (CPT©) code 91110, *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through iliem, with physician interpretation and report,* to be reported with revenue code 329, *Diagnostic radiology, other*, for outpatient hospital procedures. CPT code 91110 reported with revenue code 329 will reimburse a rate of $520.95 based on the procedure code allowed amount. Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.
- IHCP providers are reminded to review IHCP provider bulletin *BT200502* dated February 25, 2005, regarding changes in spend-down rules. When submitting statements of charges for spend-down purposes, providers must indicate whether they will bill Medicare or other insurance, and the Medicare approved amount for the service, if known.
- The Office of Medicaid Policy and Planning (OMPP) will implement Hoosier Healthwise mandatory risk-based managed care (RBMC) enrollment across all Indiana counties in 2005. This will transition current Prime*Step* Hoosier Healthwise managed care members from Primary Care Case Management (PCCM) into enrollment with a local managed care organization (MCO) in the RBMC delivery system.

  Primary medical providers (PMPs) in the affected counties can choose to contract with one of the Hoosier Healthwise MCOs. Prime*Step* PMPs who switch to one of the MCOs before the final transition date will retain their current Hoosier Healthwise members. Specialists, hospitals, and ancillary providers may have various MCO arrangements depending on factors such as how many of the MCO's members may be served by the provider, or how many MCOs are serving their region. The transition schedule, regional map, questions and answers, and additional detailed information on the transition can be found in IHCP provider bulletin *BT200506*, which is available at www.indianamedicaid.com.

  The OMPP will conduct a series of public meetings about the transition to mandatory RBMC for the Hoosier Healthwise Program. The meeting's agenda will include an overview of the transition process, individual MCO presentations, and the opportunity to ask questions of the MCOs. The details of upcoming scheduled meetings on the transition to mandatory RBMC are as follows:

  1) Bartholomew County Area Public Meeting: April 5, 2005, at the Columbus Regional Hospital Auditorium (2400 East 17th St., Columbus, Ind.). The meeting will be held from noon to 1 p.m.

  2) Wayne County Area Public Meeting: May 10, 2005, at Reid Hospital Auditorium (1401 Chester Blvd. Richmond, Ind.). The meeting will be held from noon to 1 p.m.

  3) Tippecanoe County Area Public Meeting: To be scheduled.
- Effective April 1, 2005, the IHCP will no longer accept electronic claim transactions that are not compliant with Health Insurance Portability and Accountability Act (HIPAA) requirements. Files received after this date in a non-compliant format will not be processed. Currently, the majority of providers are submitting claims in a HIPAA-complaint format. EDS has been contacting providers and software developers to assist them in becoming HIPAA compliant before this deadline. Providers have the option of using IHCP Web interChange as an alternative method of claims submission. Web interChange can be accessed from the IHCP Web site. Providers should direct questions about the claims submission process to the Electronic Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.
- This article provides updated crossover claim information to educate providers about options available for submitting crossover claims for dually eligible members, or for members covered by private insurance. The following additional information is available on the IHCP Web site at www.indianamedicaid.com.

Table 1 – Crossover and TPL Claims

837 Billing of Crossover Claims to Medicare
837 Billing of Crossover Claims Directly to the IHCP
837 Billing of TPL Claims

Electronic submission of crossover claims decreases the need to submit paper claims, allows for adjudication of claims in a more efficient and timely manner, and eliminates potential keying errors. To increase the volume of electronic claims that automatically cross over from Medicare, the IHCP requests that providers include information needed by the IHCP for adjudication when submitting the 837 electronic transactions to Medicare. Refer to the 837 Billing of Crossover Claims to Medicare link on the IHCP Web site for additional information.

Web interChange and EDI vendor or clearinghouse options are available to providers for claims denied by Medicare, or for claims that do not cross over electronically to the IHCP. Providers should refer to the Billing of Crossover Claims Directly to the IHCP link on the IHCP Web site for additional information.

How to Resubmit a Denied Crossover Claim

Web interChange allows providers to access denied claims and to use the *Copy This Claim* function, which allows providers to make necessary corrections for resubmission of new claims. This function eliminates the need for rekeying the entire claim. Monitor the monthly provider newsletter as well as the IHCP Web site for future updates about submitting crossover claims using Web interChange. Providers should direct questions about this information to the EDI Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182, or by e-mail at INXIXTradingPartner@eds.com.

- This article specifies revisions to the billing instructions for radioimmunotherapy services using Zevalin or Bexxar. This supplements the article published in the November 2004 provider newsletter *NL200411*. Effective October 1, 2004, revenue code *343, Diagnostic radiopharmaceuticals*, and revenue code *344, Therapeutic radiopharmaceuticals*, became valid revenue codes. Providers may use these revenue codes for dates of service on or after October 1, 2004, to report radiopharmaceuticals used for the Zevalin or Bexxar regimen as listed below.

Table 2 – Billing for Radioimmunotherapy Using Zevalin or Bexxar

Code	Code Description	Revenue Code(s)
C1080	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose	343, 636
C1081	Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per dose	343, 344, 636
C1082	Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose	343, 636
C1083	Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per dose	344, 636

The article in *NL200411* listed HCPCS code Q0084, *Chemotherapy administration by infusion technique only, per visit*, to be reported for the administration of rituximab in the Zevalin regimen for the treatment of non-Hodgkin's lymphoma. Effective for dates of service on or after January 1, 2005, Medicare requires Outpatient Prospective Payment System (OPPS) hospital facilities to bill the appropriate CPT code for chemotherapy administration instead of HCPCS code Q0084. In order to comply with Medicare regulations for OPPS hospital facilities, providers are required to utilize one of the codes listed below for the administration of rituximab in the Zevalin regimen for dates of service on or after January 1, 2005.

Table 3 – Administration of Rituximab in the Zevalin Regimen

Code	Code Description	Revenue Code
Q0084	Chemotherapy administration by infusion technique only, per visit	335
96410	Chemotherapy administration, intravenous; infusion technique, up to one hour	335
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	335
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	335
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	335

Providers may direct questions to EDS customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800 577-1278.

To All IHCP-Enrolled Hospice and Nursing Facility Providers:

- Effective April 1, 2005, hospice providers will not be required to submit individual claim adjustment forms to EDS for retro rate adjustments for room and board payments under the IHCP hospice benefit. System changes have been completed that allow mass adjustments for the nursing facility room and board rates of hospice claims billed under bill type 822 with hospice revenue codes 653, 654, 659, 183, and 185. The system change permits hospice claims under the revenue codes listed above to be mass adjusted on the same date that the nursing facility retro rates are mass adjusted. This change will expedite hospice claim payments to contracted nursing facilities. Hospice and nursing facility providers are reminded that mass adjustments to the room and board rate under the IHCP hospice benefit for members residing in nursing facilities will be reflected on the hospice provider's remittance advice (RA). Hospice and nursing facility providers are encouraged to develop coordination and payment procedures to address this retro rate adjustment issue in their contracts.